Name of individual placing referral:

Date:

Affiliated agency:

Agency's address:

Contact number:

Contact email:

Participant's name:

Pronoun: O She, O He, O They, O Other: \_\_\_\_

Date of Birth:

Primary caregiver (if applicable):

Participant's address:

Contact number:

Contact email:

If necessary, is it okay to leave a message at this number? O Yes, O No

Service(s) participant is interested in receiving through GMWC:

O Psychotherapy

O Physical Health Monitoring

O Wellness Management

O Medication Management (non- prescribing)

O Individual Skill Development and Enhancement

O Psychoeducation

Participant is Interested in receiving service[s] at/ via:

O Home

O Community

O Office

O Tele therapy

O Other: \_\_\_\_\_\_\_\_\_\_

Please note where applicant is in terms of readiness for change:

O Precontemplation

O Contemplation

O Preparation

O Action

O Maintenance stage

When is participant looking to start services with GMWC:

Days/ times participant is interested in meeting:

Does the participant have preferences for a provider that should be considered during review? If yes, please explain:

Relevant information regarding mental or physical health diagnosis[es]:

Participant’s perception of the goal[s] to be worked on through services interested in:

Participant’s perception of barriers and needed areas of additional support in working towards goals:

Please feel free to provide any additional information you would like GMWC to know at this time in the process:

***Please fill out and submit for review to bethg@Goldenmend.org***